Department of HUMAN SERVICES

Integrated Health Home Workgroup Meeting March 16, 2022

March 16, 2022

Role Call

Format of Workgroup

- Discuss prior meeting (high level)
- Topic for the meeting
- Plan and expectations for next meeting

It is ok to ask questions during the meeting and between meetings. These questions and answers will be shared at the beginning of each meeting.

What is Our Why? What Do We Want to Accomplish?

- Identify how the Health Homes meet the provider standards set forth by the federal government as well as identify appropriate oversight of those standards.
- Develop a proposal for a payment methodology that is consistent with the goals of efficiency, economy, and quality of care. The rate will be developed according to the actual cost of providing each component of the service.
- Review member qualifications in order to propose qualifications that meets federal and state code.
- Update Health Home Services to reflect whole-person team based-care while reducing provider burden.
- Develop a Quality Improvement model that can be adopted by Integrated Health Homes.
- Develop a proposal to present to the State that encompasses all the forementioned goals.

Ground Rules

- You can respect another person’s point of view without agreeing with them.
- Respectfully challenge the idea, not the person and bring potential solutions.
- Blame or judgment will get you further from a solution, not closer.
- Honest and constructive discussions are necessary to get the best results.
- Listen respectfully, without interrupting.
- Listen actively and with an ear to understanding others' views. (Don’t just think about what you are going to say while someone else is talking.)
- Commit to learning, not debating. Comment in order to share information, not to persuade.
- Avoid blame, speculation, and inflammatory language.
- Allow everyone the chance to speak.

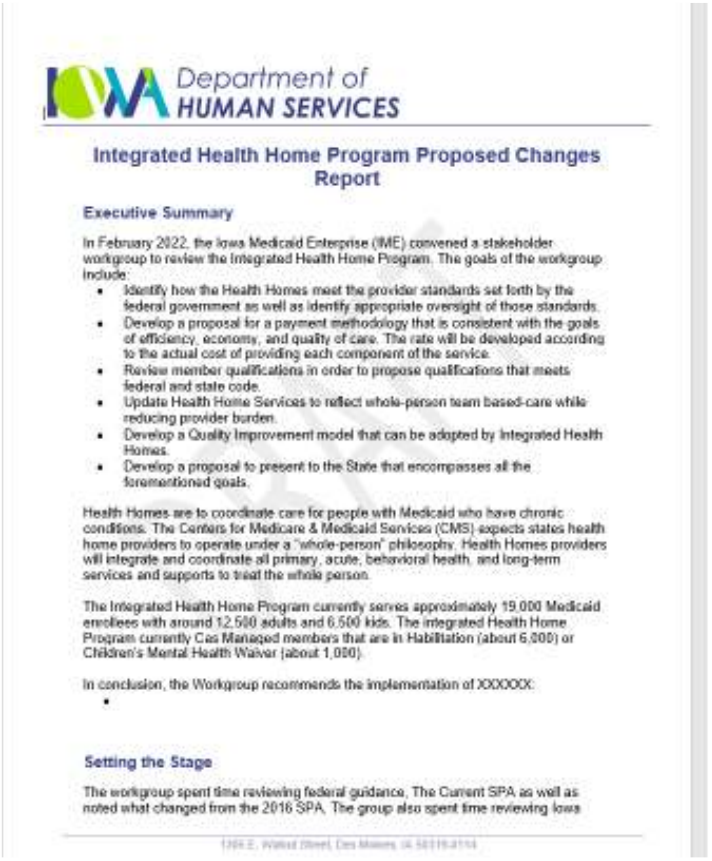
Objectives

- Review of Last Meeting
- Workgroup Report
- Discussion with Karen Hyatt DHS and Peer/Family Peer Trainers
- Survey, Listening Sessions, and Site Visit Report
- Provider Standards Deep Dive

Last Meeting

- Reviewed the timeline and plan for the next few months
- Reviewed much of the current SPA along with what has changed from the previous SPA and what still needs implemented.
- Plan for the next meeting and discussed what may be needed to support the work
- Questions/Answers

Workgroup Report



Department of HUMAN SERVICES

Integrated Health Home Program Proposed Changes Report

Executive Summary

In February 2022, the Iowa Medicaid Enterprise (IME) convened a stakeholder workgroup to review the Integrated Health Home Program. The goals of the workgroup include:

- Identify how the Health Homes meet the provider standards set forth by the federal government as well as identify appropriate oversight of those standards.
- Develop a proposal for a payment methodology that is consistent with the goals of efficiency, economy, and quality of care. The rate will be developed according to the actual cost of providing each component of the service.
- Review member qualifications in order to propose qualifications that meets federal and state code.
- Update Health Home Services to reflect whole-person team based-care while reducing provider burden.
- Develop a Quality Improvement model that can be adopted by Integrated Health Homes.
- Develop a proposal to present to the State that encompasses all the forementioned goals.

Health Homes are to coordinate care for people with Medicaid who have chronic conditions. The Centers for Medicare & Medicaid Services (CMS) expects states health home providers to operate under a "whole-person" philosophy. Health Homes providers will integrate and coordinate all primary, acute, behavioral health, and long-term services and supports to treat the whole person.

The Integrated Health Home Program currently serves approximately 19,000 Medicaid enrollees with around 12,500 adults and 6,500 kids. The integrated Health Home Program currently Cas Managed members that are in Habilitation (about 6,000) or Children's Mental Health Waiver (about 1,000).

In conclusion, the Workgroup recommends the implementation of XXXXXX:

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Setting the Stage

The workgroup spent time reviewing federal guidance, The Current SPA as well as noted what changed from the 2016 SPA. The group also spent time reviewing Iowa

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Administrative Rule that open for comment. The group discussed information that might be helpful for them to review to assist in identifying improvements to the SPA. There were suggestions for process reviews as well the identification for areas that will need to be discussed during a deeper dive into the requirements. These were added to the plan for future discussions and will be incorporated into next steps if they do not require an update to the SPA.
Review of the Health Home Survey, site visit, and listening sessions.

Diving into the Details

Health Home Provider Standards

Payment Methodologies

Team Qualifications

Health Home Services

- **Comprehensive Care Management**
- **Care Coordination**
- **Health Promotion**
- **Individual and Family Support**
- **Referral to Community and Social Support**

Quality Improvement

Conclusion and Next Steps

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Overview of the Timeline

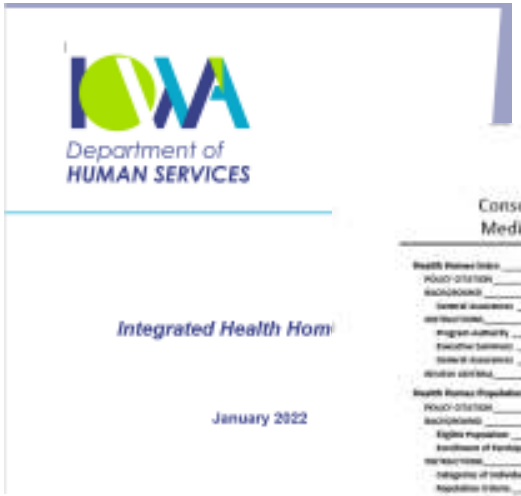
Department of HUMAN SERVICES

Health Home Quality Improvement Workgroup

The Health Home Quality Workgroup is tasked with the development of learning topics and activities. This workgroup will meet biweekly from 9am to 11am. Proposal will be submitted to IME for review. The plan is to update the SPA based on approved recommended changes.

Date	Topic IHH
February 2, 2022	Level Setting • Federal Requirements • OIG Final Report/State's response
February 16, 2022	Level Setting • Integrated Health Home SPA o What are we meeting now? o What changes were made and why? (Added, Edited, or deleted) o ~~Flow chart of what is the authority (Federal code, Iowa code, SPA…)~~ o Include SPA from 2016 as supporting documentation. • ~~Iowa Administrative Rule (draft) if they are available~~
March 2, 2022	Finish Reviewing the IHH SPA (Starting with Health Promotion) o What are we meeting now? o What changes were made and why? (Added, Edited, or deleted) o Flow chart of what is the authority (Federal code, Iowa code, SPA…) o Include SPA from 2016 as supporting documentation. Iowa Administrative Rule (draft) ~~Review of the site feedback, survey, and Listening Sessions.~~
March 16, 2022	Review of Last meeting's feedback Review of the site feedback, survey, and Listening Sessions. Health Home Providers Provider Standards • How does the Health Home Meet? • Peer Support and Family Peer Support IHH responsibility to coordinate services when they qualify for Habilitation/CHW, but services are not available. • Managing Habilitation and CMHW
March 30th, 2022	Review of Last meeting's feedback
	Provider Standards • How does the MCO/Iowa Medicaid support and oversee? • Address feedback of MCO/IME Administrative Oversight Burden • Using the larger organization to support the work
April 13, 2022	Review of Last meeting's feedback Payment Methodologies • Health Home Services documentation on the claim. Member Qualifications • MCO/IME Support of Provider Enrollment Activities • How does CMH and Habilitation fit into this? • Address the LMHP requirement for FI (propose recommendations) o Multiple ask for records, incomplete records, refusing to share records. o Causes an access to Health Home Services barrier o Health Home doesn't want to turn away eligible members o Causing provider abrasion between LMHP and HH o Creates bottleneck
April 27, 2022	Review of Last meeting's feedback Team Qualifications • Peer Training (age requirement, additional training, support needs of the IHH) Health Home Services: Include discussion of who can do what. Also examples of documentation. Include HIT requirements for specific services. Function and roles. • Comprehensive Care Management o Hab/CMH vs Health Home Requirements need clarified o Discuss team roles and responsibilities • Care Coordination o Hab/CMH vs Health Home Requirements need clarified o Discuss team roles and responsibilities • Health Promotion o Peer definition limiting (model instead of Program) o Discuss team roles and responsibilities
May 11, 2022	Review of Last meeting's feedback Health Home Services Include discussion of who can do what. Also examples of documentation. Include HIT requirements for specific services. Function and roles. • Comprehensive Transitional Care o Peer definition limiting (model instead of Program) o Discuss team roles and responsibilities • Individual and Family Support o Review the requirement of being in the plan to complete it. Need agility in the services. o Discuss team roles and responsibilities • Referral to Community and Social Support Services o Discuss team roles and responsibilities
May 25, 2022	Review of Last meeting's feedback Quality Improvement • Learning Collaborative contents • Newsletter • IHH Internal QI/QA structure
June 8, 2022	Review of Last meeting's feedback Quality Improvement • IHH Internal QI/QA structure
June 22, 2022	Putting it all together. Presentation of Draft Proposal.

Documents for Today



11 Health Home Core Functions

- Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered health home services.
- Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines.
- Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders.
- Coordinate and provide access to mental health and substance abuse services.
- Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care.
- Coordinate and provide access to chronic disease management, including self-management support to individuals and their families.
- Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services.
- Coordinate and provide access to long-term care supports and services.
- Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services.
- Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate; and
- Establish a continuous quality improvement program and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.

Delivery System Principles

- Demonstrate clinical competency for serving the complex needs of health home enrollees using evidence-based protocols.
- Demonstrate the ability for effectively coordinating the full range of medical, behavioral health, long-term services and supports, and social services for medically complex individuals with chronic conditions.
- Provide health home services that operate under a "whole-person" approach to care using a comprehensive needs assessment and an integrated person-centered care planning process to coordinate care.
- Have conflict of interest safeguards in place to assure enrollee rights and protections are not violated, and that services are coordinated in accordance with enrollee needs expressed in the person-centered care plan, rather than based on financial interests or arrangements of the health home provider.
- Provide access to timely health care 24 hours a day, 7 days a week to address any immediate care needs of their health home enrollees.
- Have in place operational protocol, as well as communication procedures to assure care coordination across all elements of the health care system (hospitals, specialty providers, social service providers, other community-based settings, etc.).
- Have protocols for ensuring safe care transitions, including established agreements and relationships with hospitals and other community-based settings.
- Establish a continuous quality improvement program that includes a process for collection and reporting of health home data for quality monitoring and program performance; permits evaluation of increased coordination and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.
- Use data for population health management, tracking tests, referrals and follow-up, and medication management.
- Use health information technology to link services and facilitate communication among interdisciplinary team members and other providers to coordinate care and improve service delivery across the care continuum.

Peer and Family Peer

Introduction of Staff

- Karen Hyatt DHS
- Kellee McCrory University of Iowa

Report

Goals

- Understanding the demographics of Health Homes.
- Assess time spent on the road, providing ICM/non-ICM services, and time spend on administrative work.
- Capturing Health Homes thoughts on what is important when determining a PMPM rate.
- Identifying barriers to providing whole-person team-based care to all enrolled members.
- Understand how Health Homes measures quality and outcomes.

Findings

- Almost 70% of enrolled members are Adult or Habilitation.
- More providers are both rural and urban than urban or rural alone.
- There are more providers that serve both adult and child (18) then either serve children or adults (15).
- Most Health Homes have an EMR that supports meaningful use activities (promoting interoperability) than do not.
- Care Coordinators spent more time providing ICM Services than any other team member.
- 15 Health Homes Have ICM and non ICM dedicated staff compared to the 18 that do not. This does not correlate with adult/child or rural/urban demographics.
- As expected, rural providers spend significantly more time on the road than urban.
- Reimbursement rates, salaries and benefits, and administrative expenses are the top three barriers to the optimal ratio.

Findings Continued

- Staffing ratio, current staff wages and benefits, and other were identified as the top three considerations for developing the rate.
- Many topics were identified when asked what does not bring value:
  - Documentation
  - Managed Care Portals
  - Reports
  - Staffing
  - Learning Collaborative
  - Lack of Providers
  - Obtaining Information from Other Providers
  - Oversight
- There were a variety of responses to assist in understanding what quality and outcomes mean to them:
  - Chart Review Workbook Results
  - Spreadsheet Tracking
  - Reports/Metrics
  - Internal Audits
  - Quality Improvement Meetings
  - Patient Satisfaction
  - Stakeholder Surveys

Demographics

A survey and listening sessions were completed in order to obtain qualitative and quantitative data from the Integrated Health Homes.

- 33 out of 35 Integrated Health Homes completed surveys and attended one or more listening session.
- Associations and Coalition participated in the listening sessions.
- Iowa Association of Community Providers (IACP), Iowa Behavioral Health Association (IBHA), and Children's Coalition reached out to their members to ensure they completed surveys.

Urban vs Rural Iowa 2010 Census

Rural/Urban	Rural	Urban	Percentage
Population	1,096,099	1,950,256	36% to 64%
Land Area (Square Miles)	54,904	953	98% to 2%

Rural/Urban and Adult/Child Demographics

Rural/Urban	Adult	Child	Both
Urban	1		
Rural	5	2	8 (72% A to 28%C)
Both Rural/Urban (71% Rural to 29% Urban)	3	4	10 (73% A to 27% C)

Annual Enrollments by Year

Year	Count
2018	17,357 Unique Members
2019	16,561 Unique Members*
2020	17,896 Unique Members
2021	18,744 Estimated

* 2019 there was a transition of MCOs potentially causing this enrollment to be low.

December 2021 Monthly Enrollment

Tier	Count	Percent of Total
Adult	6,879	37%
Child	4,912	26%
Habilitation	6,012	32%
Children's Mental Health Waiver	987	5%
Total	**18,790**	**100%**

Meaningfully Using Electronic Health Records

Health Homes were asked if they had a 2015 certified Electronic Health Record. Some marked no because they didn't understand the question. Most Health Homes stated that they have a 2015 certified Electronic Health Record. There were four Health Homes that do not have a certified Electronic Health Record or ones that were certified at one time. EHRs are expensive to purchase and expensive to maintain. Through discussions with these Health Homes. They seem to have much of what is needed to support the Health Home Program, but more research is needed.

Time Spent on ICM Core Services

All	None	1-3 Hours	4-6 Hours	7-10 Hours	> Than 10 Hours
Directors	14	11	4	2	1 (22.5)
Supervisors (3 No Answer)	7	5	1	6	10 (23)
Nurses		8	8	8	8 (21)
Care Coordinator			4	1	27 (23.5)
Peer Support (1 No Answer)	1	19	6	3	2 (22.5)

Time Spent on Non-ICM Activities

All	None	1-3 Hours	4-6 Hours	7-10 Hours	> Than 10 Hours
Directors	15	10	5	2	0
Supervisors (2 no Answers)	8	9	6	4	3 (22)
Nurses	0	8	6	4	14 (23)
Care Coordinator	1	2	5	7	17 (25)
Peer Support (1 No Answer)	0	3	2	4	22 (24)

Non-Service-Related Activity

All	None	1-3 Hours	4-6 Hours	7-10 Hours	> Than 10 Hours
Directors	1	6	3	6	16 (25)
Supervisors (2 no Answers)	5	2	6	6	11 (22)
Nurses	3	12	6	6	5 (17)
Care Coordinator (1 No Answer)	1	13	10	4	3 (13)
Peer Support (1 No Answer)	4	15	8	4	0

Time on the Road

All	None	1-3 Hours	4-6 Hours	7-10 Hours	> Than 10 Hours
Directors	22	8	1	1	
Supervisors (2 No Answer)	8	13	9		
Nurses	4	20	7	1	
Care Coordinator		8	18	5	1(15+)
Peer Support (1 no answer)		14	10	6	1(15+)

Current Caseloads

- I have a small caseload. I have currently 6 ICM and 2 Non ICM cases. My supervisor has currently a caseload of 37 ICM. Typically, I carry 5 ICM and my supervisor would carry 25 ICM.
- The team lead's caseload can vary based on several circumstances. They may be covering a full caseload depending on staff turnover or overflow of members. On average our team leads provide oversight of their teams of 8-10 team members with oversight of roughly 350 members. Right now, one team lead is carrying a caseload of 49 as a care coordinator is out on leave while another is only covering as needed for their team. One of our team leads carries a caseload of 10-15 all of the time.
- Every member is assigned to the CC, then nurses and peers serve everyone. Our peer does not have her own caseload but serves every member in our IHH. We have 2 nurses who don’t have caseloads but serves everyone in their area.

Optimal Caseloads

Respondents were asked to share what their staffing model would look like without barriers. There was not a correlation between the size, location, or adult/child with an optimal staffing model. Further discussion is needed to ensure that an optimal caseload is identified as a best practice.

Barriers To Optimal Ratio

Rating Place	Ranking	Barrier
7	6.57	Leadership
6	4.4	Workforce/Retention
4	4	Workforce/Recruitment
1	2.28	Reimbursement Rates
2	3.46	Salary and Benefits
3	3.96	Administration Expectations
5	4.3	Other

Barriers To Optimal Ratio Other

- The amount of paperwork that has been implemented over the past couple of years has resulted in numerous care coordinators resigning from the IHH. When the IHH began in 2013, the caseloads were high, but the paperwork was minimal. There was more job satisfaction at that time. IHH staff feel they are not able to spend enough time with the clients on their caseloads due to the high demands of paperwork.
- Lack of community providers for ICM services.
- Traveling, road conditions, clients resisting/not following through.
- Workforce demands with high caseload prevent IHH programs from being able to provide members with quality care due to an increase in needed services with a lack of qualified providers.
- Expectations of perfection; bad faith/negative assumptions; work-life balance
- Increasing expectation and frequent changes in documentation
- Computer systems, portals, mandatory paperwork, communication with MCOs.
- Additional expectations above and beyond the rules.
- Client retention.
- The SPA guidelines on what role is capable of providing certain service activities has forced our site to staff very Care Coordinator heavy. This combined with reimbursement is the only cost-effective way to sustain the program and meet requirements for documentation. Having more nurses would cost more and having more Peers/Family Support does not help us reach requirements we must meet due to documentation/restrictions in what services they can provide independently. It is also difficult to recruit and retain Peer/Family Support Specialists.

Rate Considerations

Rating Place	Rate	Barrier
1	2.96	Staffing Ratio
9	5.86	Wage data from the Bureau of Labor and Statistics
3	3.3	Current staff wages and benefits
7	4.9	Rural vs Urban workforce considerations
4	3.75	Time Study (How much time it takes to provide the services)
6	4.8	Travel time (Mileage reimbursement, vehicle maintenance, agency insurance cost, parking fees included)
5	4.3	Administrative Cost not related to direct delivery of Health Home Services. (Such as office cost, HR, printing and mailing, IT, accounts receivable, accounts payable, and/or operating and indirect costs).
10	6.37	Global (Flat) PMPM reimbursement rate for all Enrolled Members
11	6.36	Risk adjusted rate of reimbursement (Such as payment would be based on the acuity score or other functional assessment of a member)
8	5.1	Inflation and Rebasing (i.e., annual cost adjustment)
	6.4	Completing a cost report at regular intervals to set a rate
2	3.2	Other

Rate Considerations Other

- The gap between IHH and ICM requirements has narrowed with both populations requiring a significant amount of intensive work.
- Staff wages & benefits based on industry standards to allow IHH to be competitive with the for-profit industry; Quality Assurance & Quality Improvement are needed.
- To keep in mind that children are not mini adults and are part of a family, so the family needs to be included in who we serve and the corresponding costs. Serving parents and the family adds a lot more components to the Pediatric IHH work. This means that when looking at risk assessment and level of need, we really need to factor in the whole family and their needs that have an impact on the child's functioning and mental health.
- Having staff wages competitive with CBCM's and other like programs along with having a reasonable caseload to have client contact and complete all the required paperwork.
- Rural vs Urban workforce factors is not a consideration for EB. N/A to "other"

Risk

Some members qualify for the lower tiers but have an equal to or larger risk than a member enrolled in an HCBS Services. Lack of access to needed services, and the continued increased risk of members in general have increased the workload of the Health Home Team without increased reimbursement. Health Homes discussed a universal tool to measure risk.

Requirements that Do Not Bring Value

- Documentation
  - Functional Impairment
  - Assessment and Person-Centered (Care/Service) Plans
  - Habilitation Issues
  - Narrative Notes
- Managed Care Portals
- Reports
- Staffing
- Learning Collaborative
- Lack of Providers
- Obtaining Information from Other Providers
- Oversight

Requirements that Do Not Bring Value Documentation

Documentation requirements have been a source of provider abrasion since December of 2019. In an attempt to ensure that federal requirements are met, templates and tools were created to assist Health Homes in meeting those documentation requirements.

- Documentation standards dictate the majority of the focus within the health home. We spend far less time discussing with the MCOs how to meet patient needs than we do how to ensure documentation.
- It seems that the more cumbersome the documentation standards become, there is less attention on quality of care that filters down directly to the patients.
- Redundancy of paperwork.

Requirements that Do Not Bring Value Functional Impairment

While the statement just identified that the functional impairment requirement was burdensome without additional information, past feedback has identified how difficult it is to get this information from a mental health provider and expressed frustration over not being able to obtain this information from a primary care provider.

Requirements that Do Not Bring Value Assessment and Plan

- Several respondents feel that the documentation between the CASH, interRAI and PCSP are duplicative
- Other identified documentation as being too burdensome for the staff and member
- Respondents feel that corrections to the PCSP does not bring value
- One comment focused on the nurse spending time on the CASH and the effects on their revenue

Requirements that Do Not Bring Value Habilitation Process Issues

Respondents shared that the Habilitation process has issues that cause barriers for the Health Homes and need to be addressed to support coordinated care. Habilitation lines close when it should still remain open causing lots of additional work. Duplication of documentation and corrections to the PCSP and monitoring of provider documentation. Many of these requirements are federally mandated and cannot be changed but there are some operational processes that can be updated.

- Service Monitoring
- Habilitation line closed and needed re-opened
- HCBS Residential Assessment and PCSP has duplicate information
- Corrections on reductions and termination documentation

Requirements that Do Not Bring Value Managed Care Portals

The MRA is Iowa Total care and is used to capture information electronically at the Health Plan

The HIP is Amerigroup and is used to collect clinical information that difficult to obtain through claims

Requirements that Do Not Bring Value Reports General Feedback

- Tracking is a burden
- Inconsistencies between MCOs (i.e., different outcome measures; different processes)
- Multiple spreadsheets requesting data (employment reporting, Clients without HAB services)
- Internal Audits
- There is a lot of data tracking that is done that is very time consuming. Data tracking is important but some of what is being tracked does not bring value to the IH program
- Several of the spreadsheets including the Hab Auths no services and administrative paperwork that is repetitive
- Employment reporting & making IPES follow up calls (both seem like something the MCO should be doing)
- Extra assessments required by MCOs (HIP, Health and Risk Screener); Gathering information for MCOs that they are able to access themselves

Requirements that Do Not Bring Value Reports

IPES Survey follow-up:

- IPES Survey Reporting
- Following up on IPES surveys
- IPES survey follow-up

Ad hoc report requests:

- Requesting data needed by the MCOs. In the past, things like how many clients attended school virtually during covid for example
- COVID Vaccine Reporting
- COVID reporting
- Random assignments from MCOs and IME such as covid testing, IPES follow-up, etc. Frequently it is only required by one entity, and they say it is a state requirement, so it makes me wonder how the other one is getting their info. Seems we are being asked for info not related to IHH services all the time.
- Last minute requests for data/spreadsheets cause us to drop everything

Requirements that Do Not Bring Value Reports Cont.

Critical Incident Reporting:

- CIR reports
- Critical Incident Report review reports --> information is based on claims from prior months
- Entering ER incident reports that are 2-3 months old based off of claims reports

Employment Reporting:

- Employment reporting
- Lack of consistency with employment reporting requirements between the MCOs
- Employment data
- Gathering of employment data
- Completion of the vocational questions quarterly. It is already asked on the CASH and PCSP, so we actually are reporting it 6x a year

Requirements that Do Not Bring Value
Staffing

Staffing and staffing ratio has been a voiced concern with Health Homes, especially around the Per-Member-Per-Month reimbursement model.

One respondent stated “We do not currently have a director. The Nurse Care Manager is also the co-coordinator/supervisor of the IHH program. The team works together to cover the duties previously covered by the former director, which can make it difficult to complete additional tasks requested/required.”

Others identified:

- The documentation required is far too detailed to be possible to complete at the current staffing ratios.
- Not enough time with members.
- Turnover high due to high caseload.

Inconsistencies Not Noted Elsewhere

- ITC Attestation Form
- Chart review results

Requirements that Do Not Bring Value Learning Collaborative

"Webinars where they read the slides and are basic knowledge. Ex: Webinars where the presenter reads the screens and does not elaborate."

Requirements that Do Not Bring Value Information from Other Providers

- Time spent obtaining functional impairment form from mental health professional along with mental health records. It can take multiple repeated requests and phone calls to get the correct information from the mental health professionals. Primary care should be allowed to be included and the functional impairment should be able to be completed by the IHH again but have a medical professional verify allowable mental health diagnosis.

- Tracking down clinical documentation for referrals who might not get approved for IHH, but we still provide support during that time frame.

- Repeatedly requesting records for enrollment from outside providers

- Time it takes to get tier justifications from providers, help them word it accurately, track that we asked for it and received it.

Requirements that Do Not Bring Value Program Oversight/Other

- The IHH is supposed to be considered a low-cost service comparatively for the population we serve, so it is very difficult to understand the rigorous and constant auditing and documentation oversight that providers with higher cost services don't even have to go through. Chapter 24 audits for accreditation aren't even this rigorous or frequent.
- Frequency of the changes.
- Self-Assessment
- 14-day turnaround for file requests.

Other

- QI/QA committee
- Public speaking engagements
- Community relations
- Agency promotion

Measuring Quality and Outcomes

Measuring Quality and Outcomes Quality Improvement Program

Two Health Homes provided responses that identify a quality improvement program:

- Our agency measures quality and outcomes by establishing clear priorities at the beginning of the fiscal year that reflect HEDIS measures and the State Plan Amendment. If internal goals fall behind our metrics, we put into place an improvement plan to address the outcome.

- Key performance indicators are established each year and monitored closely. Data is reported out quarterly and plans are developed to ensure progress is being made towards achievement.

Measuring Quality and Outcomes Categories

There were a variety of responses that were put into categories to gain an understanding of what quality and outcomes mean to them:

- Chart Review Workbook Results
- Spreadsheet Tracking
- Reports/Metrics
- Internal Audits
- Quality Improvement Meetings
- Patient Satisfaction
- Stakeholder Surveys

Measuring Quality and Outcomes Chart Review Workbook

IME implemented a Chart Review Workbook in December of 2019. Health Homes were encouraged to incorporate the Chart Review Workbook into their own Quality Assurance Process if they didn't already have one. A few identified that they either use the Chart Review Workbook or use the file review results from IME and the MCOs to determine quality improvement activities.

Measuring Quality and Outcomes Internal Audits

There is a role for quality assurance in the program, so it is important to capture quality assurance activities.

- We follow monthly internal auditing and tracking as well as the file audit spreadsheet given by MCO's
- Six identified Internal Quality Assurance Audits
- review of encounter notes
- Perform case file review of random sampling on open/closed records to review/assess/measure access, efficacy, safety, and timeliness
- utilizes the State issued chart review workbook to ensure quality and compliance
- Quarterly Internal Chart Reviews

Measuring Quality and Outcomes Spreadsheets

While Health Homes are required to have an EHR that assists in providing Health Home Services, many still utilize spreadsheets for tracking gaps in care.

Health Homes identified tracking hospitalizations, ED, and follow-up. Another Health Home shared "*A detailed breakdown of the expense categories that comprise the total amount approved" another stated "A very brief description of position requirements to provide services. These are usually aligned with Chapter 24, Iowa Code or State Standards*."

One Health Home mentioned that they have an excel dashboard to measure outcomes another shared that the director or supervisor tracks outcomes data on a master tracking spreadsheet. "*Each team member is responsible for tracking monthly caseload and data and reporting this back to the Supervisor and Director weekly and monthly once fully completed*."

Measuring Quality and Outcomes Reports/Metrics

- Two Health Homes specifically call out that they use their EHRs for quality improvement
- One Health Home shared a broad statement "*by outcomes reports and quality improvement processes*".
- Some Health Homes use the Pay for Performance data to identify quality improvement activities
- Other Health Homes shared specific metrics that they use to inform quality improvement activities
- Health Homes also identified ways they are ensuring standards are met

Measuring Quality and Outcomes
QI Meetings

Health Homes should be identifying improvements in addition to ensuring standards are met.

- Monthly Quality Improvement meetings
- We meet every week for a clinical meeting. We review the performance. measures and put things in place to try to meet those measures and improve upon those measures
- Quality Improvement Committee
- Have an internal QI team that meets regularly. Developed an internal team for health promotion ideas

Measuring Quality and Outcomes
QA Meetings

- We have monthly (usually) QI meetings. The IHH director has started choosing one item every few months to QA to help ensure we keep things fresh in our minds as to what needs to be completed (such as our CIR checklist, Transition of care checklist, Staffing checklist, etc.). Without this, the numerous steps needed for all of these tasks get forgotten in the daily work.
- We meet every week for a clinical meeting. We discuss cases where the team has concerns. The meetings are with therapists, medication providers, IH care coordinators, and the IH program manager. This helps everyone to be on the same page with the member and to provide the best care possible. The care coordinators do a tremendous amount of tracking data for funding, assessment dates, person-centered plan dates, risk stratification, etc. As a director, I review a sample of documentation, assessments, and plans monthly.
- Regular IHH team meetings to improve adherence with standards expected according to the SPA and MCO's/IME.
- The nurse & Director review every incident report. Internal process to review ICM paperwork prior to submission to the MCO, etc. Ongoing tracking of authorizations, plans, LOC, releases of information/rights/appeals, non-ICM assessments and plans. Discussions in weekly team meetings including education on these topics.
- Success stories identified during staff meetings.
- Compliance committee review of all critical incidents. Meeting standards of COA (accreditation).

Measuring Quality and Outcomes
Member/Patient Satisfaction

- Client Satisfaction
- We offer families the opportunity to complete satisfaction surveys, as well as the SDQ which asks scaling questions.
- A twice a year satisfaction survey is sent to clients.
- We complete client and provider satisfaction surveys
- Occasional surveys to members requesting feedback on quality of services provided by the IHH. Though this has not occurred for a couple years
- Annual completion of patient satisfaction surveys
- Survey clients for satisfactions.
- Client surveys.
- Annual Client Survey

Measuring Quality and Outcomes Stakeholder Survey

The stakeholder surveys are important in the identification of quality improvement activities around improving how Health Homes engage with other providers that also provide services to the same population.

- Stakeholder Survey
- Survey referral sources

Next Steps

- Review of this meeting's feedback
- Review Updated Workgroup Report
- Review Provider Standards